admin
THE SOUTH CAROLINA
DEPARTMENT of ADMINISTRATION

SAFETY PROGRAM: July 2015

REPORTING AN INJURY/ILLNESS OF A CONTRACTED EMPLOYEE HIRED THROUGH MARATHON STAFFING, INC.

The injured/ill employee is to report such at the time of occurrence to his/her Production Team Leader / Supervisor who will:

1. Notify David Hawkins of Marathon Staffing, Inc., by telephone, WP (803) 753-1772 or Cell (803) 760-3784, of the incident
2. Notify Department of Administration Safety by telephone of the incident:
    a. Holly Bockow, WP 737-2311 / Cell 513-5354
3. Have the injured/ill employee, witnesses and supervision complete the following accident forms and send via electronic scan or fax to:
    a. Don Buckner of Marathon Staffing, Inc., at:
        i. E-mail: dhawkins@marathonstaffing.com
        ii. Fax: (803) 760-3784
        iii. Address: 1314 Lincoln Street, Suite 306,Columbia, SC 29201
    b. Department of Administration Safety at:
        i. E-mail: Holly.Bockow@admin.sc.gov
        ii. Fax: 734-0515

If the injury/illness is not serious (does not need an ambulance for transport to the emergency room), Marathon Staffing will coordinate care for the injured/ill employee and direct where to go for that care.

Holly Bockow, Department of Administration Safety, will follow-up with the injured/ill employee's supervisor and the employee until his/her return to full duty.

The following documents and included procedures are required by Marathon Staffing, Inc. for accident reporting.

Employee Statement

Employee Name _____ Date of Incident/Injury _____

1. How did the incident occur? _____
   _____
   _____
2. When did the incident occur? Day/Date _____ Time _____ a.m. or p.m.
3. Where exactly did the incident happen (i.e. machine #, dept.) ? _____
4. What were you working on when the incident happened (i.e. product/product #)_____
5. What part of the body was injured (be specific i.e. left or right side of body part)?_____
6. What specific activity were you engaged in when incident occurred?_____
7. Were you using a tool or piece of machinery when injured:

   Please describe_____

   _____
8. Were there any Witnesses to your incident? Yes or No If yes, please list the names_____

Comments

_____

_____

_____

_____

_____

To the best of my knowledge the above questions are answered truthfully, Sworn to me this ___ day of _____ 20____.

I understand that I will need to submit to a drug/alcohol test according to the company drug/alcohol policy.

_____ _____

Employee Signature Date

EMPLOYEE STATEMENT

Employee Name: **Date & Time Incident Occurred:**

(use another sheet if needed)

Employee Print Name: **Employee Signature**

Date:

Work Related Incident/Injury Investigation
Witness, Manager, Staff Person and Group Leader Statement

Employee Name _____ Date of Incident/Injury _____

Name of Person Completing Statement _____ Position _____

1. Were you in the area where the incident happened? _____
2. Where exactly did the incident happen?_____
3. Did you see the incident happen?_____
4. What exactly did happen?_____
   _____
5. Was it obvious that the employee was hurt?_____
6. What part of the body was injured (be specific i.e. left or right side of body part)?_____
7. Was the employee using a tool or piece of machinery when injured?
   Please describe_____
   _____

8. Have you ever heard the employee complain of similar injury or illness?_____
9. Have you ever heard the employee talk about on-the-job injury before?_____
10. Are you aware of any other incidents, personal or on-the-job, that this employee has had?

    If so, describe_____
    _____

11. Did the employee violate a known safety rule?_____
12. Did you know for a fact that employee was aware of safety rule?_____
13. Do you know if employee was ever cautioned by manager or anyone else about unsafe work habits?_____
14. What do you think caused the incident?
15. What can be done to prevent a similar incident in the future?

_____

_____

Comments

_____
_____
_____
_____

(Please use the second page for additional space)

To the best of my knowledge the above questions are answered truthfully, Sworn to me this ___ day of _____ 20____.

_____ _____

Employee Signature Date

WITNESS STATEMENT

Witness Name:

Employee Name: **Date & Time Incident Occurred:**

(use another sheet if needed)

Witness Print Name: **Witness Signature**

Date:

Refusal for Medical Treatment

I, _____ was orally offered medical treatment

by _____, but have chosen not to be treated

at this time.

I understand that I must submit to a drug/alcohol test, complying with company policy. A fax or photostatic copy of this statement shall be considered as effective and valid as the original.

_____ _____

Employee Signature Date

_____ _____

Witness Name Witness Signature

_____

Date